The Medi-Cal Program — 1966 - 1971

A Socio-Economic Report of the Bureau of Research and Planning, California Medical Association

NOTE: *Estimates and projections contained in this Report are based on information made available in mid-1970. More current data suggest that they very probably have been understated. Hence, the reader should exercise caution in using such figures.*

CALIFORNIA'S MEDICAID PROGRAM (health care services to recipients of public assistance and to the medically needy) was implemented as Title XIX of the Social Security Act on March 1, 1966, having superseded the earlier Public Assistance Medical Care and Medical Assistance for the Aged Programs. Although the proportion varies among the various states which participate in the program, in California's case funding provided by the federal government is equal to approximately 50 percent of the total cost of care. State and county governments share the remainder in amounts which are computed under various provisions of the Welfare and Institutions Code. The declared goal of the program, known in the State as Medi-Cal, is to provide by 1977 all necessary health care services to persons classified as medically indigent.

Five-Year Expenditure Patterns

By the end of the current fiscal year (July 1970-June 1971), for which figures have already been projected, total cost of care will have increased by more than 532 million dollars, or 104.9 percent, during its five years of existence. During the same period, the total number of persons eligible will have increased 76.7 percent.

Table 1 shows the annual cost of care, by type of item or service, for each of five years since the program went into effect, as well as the percent increase in cost between 1966-67 and projected 1970-71 for each. It is noteworthy that expenditures for drugs, for hospitals and for nursing home care have each more than doubled in the five-year period. Costs for hospitalization have consistently accounted for more than one third of the total budget for cost of care. New regulations restricting hospital and nursing home utilization became effective on July 1, 1970, in an effort to keep the costs of these two services within the budgeted figures. The component listed as "other," which includes optometrists, opticians, podiatrists, payments to State Hospitals, home health agencies, laboratories, medical transportation, therapists and other providers and services, shows an increase of some 105 percent for the five-year period. Three of these four components show greater percentage increase during the five fiscal years ending June 30, 1971, than does the total for all services combined. The fourth component, Drugs, shows a percentage increase only slightly below that for all services.

Payments for dental services and for physician services rose least rapidly during these five years. Although consistently accounting for approximately one-fifth of the total cost of care, payments to physicians have shown a slight relative decline during the period. Projected dollar increases are based on anticipated total patient caseload and do not allow for increased costs of care for each patient.

Title XVIII (B) Buy-In costs, which have more than doubled in the four years for which figures are available (1967-68—1970-71), are shown separately and not included in the over-all total. Expenditures for this item are controlled by the number of persons covered by Medicare who are

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TABLE 1.—*Medi-Cal Program: Annual Expenditures by Service Component in Five Fiscal Years through June 1971 (in millions of dollars)*

Service component	Fiscal year 1966-67 Dollars	1966-67 Percent	1967-68 Dollars	1967-68 Percent	1968-69 Dollars	1968-69 Percent	1969-70[1] Dollars	1969-70[1] Percent	1970-71[2] Dollars	1970-71[2] Percent	Percent increase 1966-67 to 1970-1971
Physicians	$110.2	21.7	$122.5	21.7	$147.8	19.6	$165.9	19.1	$206.5	19.9	87.4
Drugs	37.8	7.5	43.7	7.7	56.8	7.5	58.6	6.7	76.3	7.3	101.9
Dentists	33.1	6.5	22.9	4.1	38.2	5.1	46.1	5.3	58.2	5.6	75.9
Hospitals	174.2	34.3	204.4	36.3	277.5	36.7	306.8	35.3	377.0	36.3	116.4
Nursing homes	105.6	20.8	128.6	22.9	161.6	21.4	203.2	23.4	225.9	21.7	114.0
Other[3]	46.6	9.2	41.3	7.3	72.9	9.7	88.7	10.2	95.9	9.2	105.8
Total	507.5	100.0	563.4	100.0	754.8	100.0	869.3	100.0	1039.9	100.0	104.9
Title XVIII (B) Buy-In	[4]		$12.8		$14.8		$17.9		$26.2		104.1[5]

[1]Estimated
[2]Proposed
[3]See text for items and services included
[4]Figures not available
[5]Increase from 1967-68

TABLE 2.—*Numbers and Percents of California Population Eligible for Medi-Cal Coverage and Annual Expenditures for All Services and for Physicians' Services Per Capita and Per Eligible, Five Fiscal Years through June 1971*

Fiscal year	Population (in thousands) Total	Eligible for Medi-Cal Number	Eligible for Medi-Cal Percent	Average annual expenditures Per capita Total	Per capita Physicians' services	Per eligible Total	Per eligible Physicians' services
1966-67	19,070.7	1298.2	6.8	$26.61	$ 5.77	$390.93	$84.83
1967-68	19,408.0	1475.7	7.6	29.03	6.30	381.71	82.83
1968-69	19,705.0	1643.6	8.3	38.30	7.51	459.24	90.01
1969-70	20,008.0	1856.9	9.3	43.45	8.30	468.15	89.42
1970-71	20,329.0	2294.5	11.3	51.15	10.16	453.22	90.01
Percent change 1966-67 to 1970-71	6.6%	76.7%	—	92.2%	76.1%	15.9%	6.1%

also eligible for Medi-Cal assistance and the Buy-In costs as established by the Social Security Administration.

Increase in Number of Medi-Cal Eligibles

As can be seen in Table 2, an increase of about one million persons (76.7 percent) in the average monthly count of beneficiaries—from 1.3 million during 1966-67 to an estimated 2.3 million for the 1970-71 year—is anticipated. During the same five years California's population will increase by about 1.3 million persons (6.6 percent) according to estimates of the California Department of Finance.

Despite this relatively rapid increase in population—an average of 1.6 percent each year—the increase in the number of beneficiaries under Medi-Cal will far exceed that of the total population. During the 1966-67 fiscal year, one person in fifteen in California received Medi-Cal benefits; during 1970-71 it is projected that this proportion will be one person in eight.

Total dollar payments for cost of care per capita and per Medi-Cal eligible are also shown for each year, together with dollar payments for physicians' services. Table 2 shows a percentage increase in total payments per eligible of approximately 16 percent, while payments for physicians' services per eligible are expected to increase just over 6 percent during the five-year period.

It is interesting to note that the average cost of the program, when shown on a per capita basis for all Californians, is expected to increase from an annual cost of $26.61 to $51.15, or 92.2 percent. As already indicated, this increase is primarily attributable to an expanding caseload, rather than

TABLE 3.—*Total Medi-Cal Costs and Administrative Costs for Three Types of Agencies, Five Fiscal Years through June 1971 (in millions of dollars)*

Fiscal year	Total Program Costs[1]	Administrative Costs				Percent Administrative Costs
		Total	Agency			
			State Government	Fiscal Intermediaries	County Government	
1966-67	$ 507.5	$21.0	N/A	N/A	N/A	4.1
1967-68	563.4	28.1	N/A	N/A	N/A	5.0
1968-69	754.8	36.6	$ 8.0	$14.6	$14.0	4.8
1969-70	869.3	42.0	8.7	20.3	13.0	4.8
1970-71	1039.9	53.6	15.1	21.8	16.7	5.2

N/A: Not available
[1]Excludes costs for Title XVIII (B) buy-in

to increased expenditures per eligible. The per capita amount allocated to physicians' services is expected to increase at a lower rate of 76.1 percent, from $5.77 to $10.16.

Administrative Costs Shown for Three Types of Agencies

Table 3 shows administrative costs of the Medi-Cal program for the years July 1966 through July 1971 in dollar amounts and as a percentage of total program costs. The years 1968-69, 1969-70 and 1970-71 are further delineated to show administrative costs by the State, the counties and the fiscal intermediaries. The total cost of administration has generally remained in the area of five percent. This proportion is expected to increase to 5.2 percent in 1970-71 for reasons which will be explained later.

County operations are concerned with the determination of eligibility by the various county welfare departments under the direction of the State Department of Social Welfare. These welfare agencies certify the eligibility of persons for medical assistance benefits.

Fiscal intermediaries include California Blue Shield, Hospital Service of California and Hospital Service of Southern California. It is estimated that these three intermediaries will pay 30.2 million claims during 1969-70 at an average administrative cost of $1.34 per payment. The projected number of claims for 1970-71 is 35.4 million with an estimated average administrative cost of $1.20 per payment.

The State administration of the Medi-Cal program involves the State Department of Health Care Services, which both administers the program and coordinates the activities of the State Departments of Mental Hygiene, Public Health and Social Welfare in their involvement with the Medi-Cal program. The sharp increase in this portion of administrative costs anticipated for the 1970-71 fiscal year is due to an increased fund request by the Department of Health Care Services (DHCS). The DHCS administrative budget has been increased from 5.7 million dollars for 1969-70 to 11 million dollars for 1970-71—a jump of 92 percent—in anticipation of realizing longer term program savings. The largest single item in this proposed increase is 4.5 million dollars for the 1970-71 support of a pilot project of a management system which would program, test, develop and implement innovative concepts in the program on a prototype basis in two counties. The project will be implemented in three phases:

	Maximum cost
1. Design Stage—7 months	$1,240,000
2. Development—11 months	2,870,000
3. Implementation—6 months	1,660,000
Total	$5,770,000

DHCS Adjusts in Five Fields to Save Money

The Department of Health Care Services indicates that its proposed budget for 1970-71 provides savings of some 49 million dollars in the cost of care by adjustments in five general classifications,* as follows:

1. *Intensify control of hospital utilization* by requiring submission of the hospitalization request ten days in advance of admission with an estimate of the length of stay for all non-emergency admissions. Notification of emergencies would be required within 24 hours of admittance. At present non-emergency hos-

*These five fields represent the program outline at the time this report was prepared. Should changes have been made subsequently, the expected effects would be changed accordingly.

pitalizations represent 20 percent of all hospitalizations. The Department estimates it can control ten percent of the non-emergency hospitalizations and thus effectuate savings of 17 million dollars.

2. *Tighten eligibility requirements for medically needy persons* by establishing a system of State certification (currently counties handle such certification), and by reducing personal property exemptions from the present $1,500 to $600 for a single person and from $3,000 to $1,200 for a family. The savings resulting from this proposal are estimated to be $13 million.

3. *Establish a schedule of maximum allowance for outpatient services.* The Department proposes to establish a Schedule of Maximum Allowances for outpatient services provided through hospitals, clinics, neighborhood health centers and other institutions. The program savings resulting from this proposal are estimated to be 5 million dollars.

4. *Establish 14 medical-social review teams* to evaluate the needs of each person in a nursing home or mental institution to determine whether or not the patient needs that level of care or could be moved to a lower cost intermediate care or residential facility.** The establishment of these medical-social review teams will serve to comply with the Social Security Act Amendments of 1967 requiring periodic inspections to be made in all skilled nursing homes and mental institutions within the State by one or more medical review teams composed of physicians and other appropriate health and social service personnel. Savings of 12.4 million dollars are expected to accrue from the operation of these review teams.

5. *Restricted utilization of psychologists and special duty nurses will be instituted.* Rather than including psychologists as individual providers, the program is recommending that these services be provided as part of a team, as found in an institutional setting. The need for special duty nursing is greatly diminished with the advent of intensive care units in hospitals; where it continues to be essential, it can be provided in a controlled hospital environment. Savings of 2 million dollars are anticipated.

**"Intermediate care facilities," as such, do not yet exist in California. However, applicable licensing regulations have been adopted and the State Health Planning Council has developed guidelines for pre-licensing approval of such facilities. The state hopes that skilled nursing homes will convert some of their beds to intermediate care within the next year.

CATHETER SITES FOR MONITORING SHOCK

By what route do you insert the catheter if you want to monitor central venous pressure in a patient in shock?

"For the physician or surgeon who is very much at home in the critical care environment, the subclavian route, I think, is a good route. You can get into it rapidly with some skill. You can maintain the catheter away from sites of interference. But, on the other hand, for the occasional operator, that area is fraught with some dangers — namely, pneumothorax, possibility of penetrating the aorta, and so on. So that for the occasional operator, I would prefer seeing the catheter placed by way of the brachial vein."

—MAX HARRY WEIL, M.D., Los Angeles

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